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Application Processing - Introduction

Applicants for an Auxiliary Grant (AG) must file a written request for assistance, report changes in their situation and provide verification of eligibility factors. An individual's eligibility must be renewed each year. Workers are required to evaluate the applications and to take action on them within certain time frames. This chapter addresses procedures for submitting and processing applications from the point of initial submission through renewals and changes in the individual's situation. It also specifies the time frames in which actions must be taken and individual's rights and reporting responsibilities.

1. Request For Assistance

A written and signed application is required for all initial applications, reapplications, and renewals. The application form to be used is the Application for Benefits. The Eligibility Review Part A, and the Eligibility Review Part B, may be used for renewals.

1.1. Interview Not Required

A personal interview is not required to determine AG eligibility. The individual or his representative may be contacted to clarify or request additional information.

1.2. Application For AG Is An Application For Medicaid

An application for AG is also an application for Medicaid and, if the individual incurred medical expenses in the three months prior to the month of application, it is also an application for retroactive Medicaid.

1.2.1. Medicaid Evaluation

1.2.1.1. Retro Medicaid

Determine retroactive Medicaid eligibility based on the Medicaid Manual, Volume XIII.

1.2.1.2. Ongoing Medicaid – AG Approval

An individual that is found eligible for AG is eligible for Medicaid. No separate Medicaid evaluation is required.

Exceptions:

If an individual fails to assign his rights to medical support and payment for medical care to the Department of Medical Assistance Services (DMAS), he/she is not eligible for Medicaid. The failure to assign rights does not impact AG eligibility.

1.2.1.3. Ongoing Medicaid – AG Denial

If AG is denied, determine Medicaid eligibility based on the Medicaid Manual, Volume XIII.

1.3. Right To Apply For Assistance

An individual cannot be refused the right to complete an application for him/herself (the applicant) or any other individual for whom he/she is authorized to apply, and under no circumstances can an individual be discouraged from asking for assistance for him/herself or any person for whom he/she is legally responsible or authorized to represent. An individual may be assisted with the application by an individual of his choice.

1.4. Applications

When an AG application is received it must be reviewed to determine if it is a complete application. An application may be complete, incomplete or invalid.

1.4.1. Complete Applications

A complete application is one that includes answers to all questions relevant to the AG program and is signed by the applicant or the applicant's representative. The application is accepted and an eligibility determination is made.

1.4.2. Incomplete Applications

An incomplete application is one that is signed by the applicant or the applicant's representative but does not include answers to any or all of the relevant questions. The application is accepted and the individual is contacted to obtain the missing information. It is not necessary to return the application to the individual. The information may be obtained in writing or verbally. If the information is obtained verbally, the date of the contact and the information received must be documented in the case record.

1.4.3. Invalid Applications

An invalid application is one that is not signed or is signed by someone that is not authorized to apply for the individual. The application is not accepted and must be returned to the individual for whom assistance is requested. A letter of explanation must be included with the returned application.

Note: The application has multiple spaces for signatures. The application is valid if the individual or his/her representative signs in either the space labeled "Applicant's or Authorized Representative's Signature or Mark" or the one labeled "Name of Person Completing Application". The application must be signed in one of these spaces to be valid. A signature on the front of the application is not sufficient.

2. Who Can Sign the Application

The application must be signed by the individual for whom assistance is requested unless the individual's condition precludes him/her from doing so or he/she has designated an authorized representative to apply for him/her. If the individual is unable to sign the application the individual's guardian, conservator or a family substitute relative may apply for him/her.

Note: Under no circumstances may an employee of, or an entity hired by a medical service provider who stands to obtain Medicaid payment file an AG/Medicaid application on behalf of an individual who cannot designate an authorized representative.

2.1. Signature By Mark

If the individual cannot sign his or her name but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below.

Example: John Doe, his mark

Witness's signature: _____

2.2. Designated Authorized Representative

The individual may authorize any adult to serve as his/her authorized representative to apply for AG. The statement designating the authorized representative must be in writing and is valid until (1) the application is denied, or (2) AG enrollment is cancelled, or (3) the individual changes his authorized representative by submitting a written statement revoking the prior designation or naming a new representative.

2.3. Individual Cannot Sign

When an individual cannot sign an initial or renewal application follow the procedure in the chart below. Detailed information follows.

STEPS	WHEN AN INDIVIDUAL CANNOT SIGN AN APPLICATION ACTIONS
Step 1	Has the individual been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate of appointment in the record? **YES:** The authorized representative is the appointed conservator or guardian. **STOP** **NO:** The individual is competent. **CONTINUE**
Step 2	Does the individual have an attorney in fact who has the power of attorney to apply for AG for the individual as evidenced by a copy of the power of attorney document in the record? **YES**: The authorized representative is the attorney in fact. **STOP** **NO:** **CONTINUE**
Step 3	Has the individual signed a written statement authorizing a person (or staff of an organization) to apply for AG on his behalf? **YES:** The authorized representative is the person or organization authorized by the individual to represent him. **STOP** **NO:** **CONTINUE**

STEPS	WHEN AN INDIVIDUAL CANNOT SIGN AN APPLICATION ACTIONS
Step 4	Is the individual able to sign or make a mark on an AG application form? **YES:** Ask the individual for his signature or mark on the application form or for a written statement authorizing someone to apply for AG on his behalf. Give the individual 10 working days to return the completed and signed application. If the completed and correctly signed application is not returned by the specified date, the application is invalid. Deny AG. **STOP** **NO:** **CONTINUE**
Step 5	Does the individual have a family substitute representative? **YES:** The authorized representative is the relative identified above who is willing and able to act on the individual's behalf. **STOP** **NO:** **CONTINUE**
Step 6	Does the individual have a diagnosis or condition that causes him/her to be unable to sign the application? **YES:** Verify the inability through a written statement from the individual's doctor. **CONTINUE** **NO:** The individual must sign or make a mark on the application or designate an authorized representative in writing. **STOP**

STEPS	WHEN AN INDIVIDUAL CANNOT SIGN AN APPLICATION ACTIONS
Step 7	Has anyone started guardian proceedings? **YES:** If action has been initiated to obtain a guardian for the individual, request verification that the action is on the court docket. Give 10 days for this verification to be provided. If the verification is provided within the 10 day period, continue to pend the application/ the individual's eligibility until the guardian or conservator is appointed. **NO:** Submit an "Eligibility Worker Referral - Medicaid Referral to APS to Request Assessment for Guardianship" form to the Adult protective Services (APS) unit. Continue pending the application/renewal until an APS decision has been made. **CONTINUE**
Step 8	Was a guardian/conservator appointed? **YES:** Give the guardian/conservator 10 days to return the completed and signed application. If the completed and correctly signed application is not returned by the specified date, the application is invalid. **NO:** The individual must sign or make a mark on the application or designate an authorized representative in writing. Give the individual 10 days to return the completed and signed application. If the completed and correctly signed application is not returned by the specified date, the application is invalid.

2.4. Guardian/Conservator

A guardian is a person appointed by a court of competent jurisdiction to be responsible for the personal affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.

A conservator is a person appointed by a court of competent jurisdiction to be responsible for the financial affairs of an incapacitated individual.

When an individual has been determined to be incompetent, his/her guardian or conservator must complete and sign the application for AG.

2.4.1. Verification

Request a copy of the guardian or conservator documents for the case record.

2.5. Family Substitute Representative

When it is reported that an individual cannot sign the application and the individual does not have a guardian, conservator, attorney in fact or designated authorized representative, one of the relatives listed below who is willing to take responsibility for the individual's AG business will be the individual's "family substitute" representative. The family substitute representative will be, in this preferred order, the individual's:

- Spouse,
- Adult child,
- Parent,
- Adult sibling,
- Adult grandchild,
- Adult niece or nephew, or
- Aunt or uncle.

2.5.1. Verification

Verification of relationship and inability to sign are not required.

2.6. No Substitute Representative Exists

If the individual is unable to sign the application and does not have an attorney in fact, authorized representative, or family substitute representative, steps must be taken to determine if the individual is in need of a guardian.

2.6.1. Verification

The individual's inability to sign the application must be verified by a written statement from the individual's doctor that says that the individual is not able to sign the AG application because of the individual's diagnosis or condition.

2.6.2. Pursuit of Guardianship

Determine if anyone has begun the process to have a guardian or conservator appointed for the individual.

2.6.2.1. Action Has Been Initiated

If action has been initiated to obtain a guardian for the individual, meaning a court guardianship hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 days for this verification to be provided.

2.6.2.1.1. Verification Provided

If the verification is provided within the 10 day period,

- **Intake**

  Continue pending the application until the guardian or conservator is appointed. If the application is still pending after 45 days, send a Notice of Action to the individual to extend the pending application.

- **Renewals**

  If all other eligibility factors continue to be met, continue the individual's eligibility until the guardian or conservator is appointed

2.6.2.1.2. Verification Not Provided

If the verification is not provided within the 10 day period, assume action has not been initiated and follow the procedures below.

2.6.2.2. Action Has Not Been Initiated

If guardianship/conservator procedures have not begun or have not been verified as being on the court docket, use the "Eligibility Worker Referral - Medicaid Referral to APS to Request Assessment for Guardianship" form to refer the individual to the Adult Protective Services (APS) unit in the local agency.

Continue an individual's eligibility or to pend an initial application until the APS investigation is completed.

2.6.2.2.1. Guardianship Will Not Be Pursued

If the completed APS investigation concludes that guardianship proceedings will not be initiated, the application must be signed by the individual, or the individual must sign a statement designating an authorized representative. Give the individual 10 days to return the signed application to the agency.

If the application form is not signed by the individual or the authorized representative and returned to the agency by the specified date, deny the application because it is invalid.

2.6.2.2.2. Guardianship Will Be Pursued

Continue an individual's eligibility or to pend the initial application until a guardian is appointed.

2.6.2.2.2.1. Guardian Appointed

Give the guardian/conservator 10 days to return the completed and signed application. If the completed and correctly signed application is not returned by the specified date, the application is invalid.

3. Place of Application

Initial applications and renewals are to be filed in the Virginia locality in which the individual last resided outside of an institution or an adult foster care home.

Note: Both public and private pay ALFS are considered institutions for AG purposes. ALFS are facilities licensed by Virginia Department of Social Services, Division of Licensing Programs for four or more individuals. Institutions also include hospitals, mental health facilities, nursing facilities, etc.

3.1. Filed In Wrong Locality

If the application is filed in a locality in which an individual does not have residence, the receiving agency must immediately forward the application to the locality of residence. The date of application will be the date it was received in the first agency.

- For example Ms. Smith lived in Hampton prior to going into the ALF. The locality that is responsible for eligibility is Hampton D.S.S.

- Ms. Smith moved in temporarily with her son who lives in Newport News before relocating to the Alf. Hampton D.S.S. is responsible for determining eligibility for AG.

- Ms. McCoy lived with her daughter in Virginia Beach for about a year and has no other residence in Virginia Beach. She has abandoned her home in Hampton with the intent to live in Virginia Beach with her daughter before going into an ALF. Virginia Beach is responsible for determining eligibility for AG.

3.2. Non-Virginia Resident

If the person did not have a prior residence in a Virginia locality or it cannot be determined where the individual last resided, the agency that serves the area in which the individual's adult living facility/adult foster care home is located will be responsible for determining initial and continuing eligibility.

4. Date of Application

The date of application is the date the signed application is received by a local department of social services. If the application is filed in a locality in which an individual does not

have residence, the receiving agency must immediately forward the application to the locality of residence. The date received in the original locality will be the date of application.

5. Information To Be Given To Individual

At the initial determination and at each renewal the individual must be given the following information.

- The individual must be given the "Virginia Department of Social Services Benefit Programs" booklet at initial application and reapplication. It does not have to be given at renewal.
- It is the individual's responsibility:
  - To provide accurate and complete information to the best of his/her ability.
  - To report changes in his/her situation within 10 days of the date the change occurred. The individual must be given a Notification of Change form.
- Failure to provide accurate and complete information or to report a change within ten days of the date the change occurs may result in prosecution for fraud.
- If the individual appears to meet SSI income standards, he/she must make application to SSI within fifteen calendar days.
- If the individual appears to be eligible for other financial benefits, he/she must make application for those benefits within a specified timeframe.
- The name of the social services agency responsible for providing social services.
- The eligibility requirements for AG and how the grant is computed.
- The requirement to verify all eligibility factors within the specified time frame.
- If eligibility factors cannot be verified, he/she will be ineligible.
- The right to dispute the current market value established for real and personal property if ineligibility results.

6. Assistance Unit (AU)

The composition of the AU determines whose income and resources will be used in determining financial eligibility. The assistance unit consists of the AG applicant only.

Exception: The AU contains both the applicant and his/her spouse when

- **As of the first moment of the month of application**
  - They were married to each other; and
  - They lived in the same household
- **Each entered an ALF/AFCH in that month;**
- **Each applied for AG in that month; and**
- **Each were determined eligible for AG for that month**

This situation can exist only in the month of application.

A **household** is common living quarters and facilities under domestic arrangements that create one economic unit. Sharing a room in an institution is not living in the same household.

7. Processing Applications

An eligibility determination begins with the receipt of a written application, continues through the verification, evaluation and documentation of each eligibility factor, and is completed at the point an eligibility decision is made, all appropriate notices are sent, and computer systems are updated.

AG and Medicaid eligibility are determined from the month of application forward. If appropriate, eligibility for retro Medicaid is determined using the Medicaid manual, Volume XIII. There is no retro eligibility for AG.

7.1. Eligibility Established

Eligibility is established when it is determined that the individual meets all eligibility requirements. Ineligibility is established at the point it is determined the individual does not meet an eligibility requirement. The worker must use the Evaluation of Eligibility to document the evaluation of each eligibility requirement.

7.2. Application Time Standards

Action to approve or deny a case must be taken within 45 days of receipt of an application. The 45-day processing period begins on the date a signed application is received in the agency. The date the approval or denial notice is mailed to the individual must be within that period. If action to approve or deny an application is not taken within 45 days the timely processing requirements have not been met.

7.2.1. Early Processing

The agency may take action prior to the 45th day of the processing period. However, an early decision will have to be reevaluated in the following situations.

- The application was denied for failure to provide verifications and the individual provides the verification prior to the end of the 45th day.
- The application was denied due to the inability to locate the individual and the individual contacts the agency prior to the 45th day.

7.2.2. Exceptions To The 45-Day Processing Timeframe

Applications whose processing is delayed beyond the 45-day processing period due to one of the following situations is not considered untimely but must be processed within the time frames noted below.

- The agency is unable to take action through no fault of its own. The pending status of the application must be continued for an additional 15 days. Final action must be taken at the end of the 15-day extension.

  Examples – Case held pending the determination of Conditional Benefit eligibility; case held pending the licensure of the ALF or approval of the AFCH.

- A disability determination is pending with SSI or Disability Determination Services **(**DDS). Action must be taken when a disability decision is made.

- An individual who must apply for SSI within 15 calendar days has applied, but the SSI decision is pending. Action must be taken when a decision is made on the SSI application.

- A guardianship determination is pending. Action must be taken when a guardian is established or it is determined one is not needed.

7.2.3. Notice of Action To Extend The Pending Period

When an application will not be processed by the 45th day, a Notice of Action must be mailed to the individual on the 45th day. The notice must state that the application is still pending and the reason action was not taken within the 45 day processing period.

7.3. Verification Requirements

The individual is responsible for providing verification of all eligibility factors. The Manual addresses each eligibility factor and the appropriate source for the verification.

- The individual must be notified in writing of the items that must be verified and the date by which the verifications must be received.
- The individual must be given a minimum of ten calendar days to return the verifications. Additional time may be allowed in situations where the individual may have difficulty in obtaining the required verifications in the ten day time frame.
- If the individual asks for help in obtaining the required verifications, the eligibility worker must attempt to obtain them.
- If the required verifications are not provided and the eligibility worker is unable to obtain them, eligibility cannot be determined and the application must be denied.

7.4. Eligibility Decisions on Applications

An AG and Medicaid eligibility decision must be made on each application and the individual and his representative must be notified of that decision.

Possible decisions include:

- **Withdrawal**
  - Individual requests that the application be withdrawn.
  - The agency is unable to locate the individual.
- **Denial**
  - The agency determines the individual is ineligible based on his failure to meet one or more of the non-financial or financial eligibility requirements.
- **Approval**

- The agency determines the individual meets all eligibility requirements.

7.4.1. Withdrawals

7.4.1.1. Voluntary Withdrawal

An individual may voluntarily withdraw his application at any time prior to an eligibility decision being made on the application. This may be done by verbal request or by a signed statement indicating the wish to withdraw the application.

The worker must:

- Document the withdrawal in the case record.
- Update the MEDPEND system, using "W" as the case disposition code.
- Send the AG Notice of Action to the individual and his representative to confirm the individual's decision to withdraw. Cite this manual reference.

7.4.1.2. Unable to Locate

If reasonable efforts to locate the individual are unsuccessful and the individual does not contact the agency so that an eligibility decision can be made within the 45-day processing period, the application will be considered withdrawn.

Reasonable efforts have been made when the agency is unable to reach the individual by phone and agency mail to the individual has been returned by the post office indicating no known forwarding address.

The worker must:

- Document the agency's attempts to locate the individual and the withdrawal in the case record.
- Update the MEDPEND system, using "W" as the case disposition code.
- Send the Notice of Action to the individual and his representative to confirm the individual's decision to

withdraw the AG and Medicaid applications. The Notice of Action must include the agency's attempts to locate the individual and request that he contact the agency. Cite this manual reference.

7.4.1.2.1. Individual Contacts Agency

If the individual contacts the agency prior to the 45th day, the application must be reopened and eligibility determined.

7.4.2. Denial of AG

Action to deny an application is taken at the point an eligibility determination finds the individual does not meet one or more of the eligibility requirements.

If the individual is ineligible in the application month and/or subsequent months but is eligible in the processing month, deny the appropriate months and approve for the processing month. See Chapter B - 7.4.3 for approval procedures.

7.4.2.1. Denial Procedures

The worker must:

- Document the denial and the reason for it in the case record.
- Assure substantiation of ineligibility is included in the case record.

  Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Update the MEDPEND system, using "D" as the case disposition code.
- Evaluate retro and ongoing Medicaid eligibility based on the Medicaid Manual, Volume XIII.

  - **If eligible for Medicaid,**

- Document the approval in the case record assuring that each eligibility factor is addressed.
- Assure that all supporting verifications are in the case record.
- Enroll the individual for Medicaid in the MMIS system.

- **If ineligible for Medicaid**
  - Document the denial and the reason for it in the case record.
  - Assure substantiation of ineligibility is included in the case record.

    Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Send a Notice of Action to the individual and his representative to notify them of the AG and the Medicaid denial or approval. State the reason the AG and Medicaid applications were denied and cite the appropriate AG and Medicaid manual references.
  - If the application is denied due to the implementation of a period of ineligibility due to an uncompensated transfer of resources, a Transfer of Resources notice must be sent with the Notice of Action.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been denied.

7.4.3. Approval of AG

Action to approve an application is taken at the point an eligibility determination finds that all eligibility requirements are met.

7.4.3.1. Entitlement Begins – Regular AG

Entitlement to regular AG begins the first month in which all eligibility factors are met. Entitlement cannot begin prior to the month of application. There is no retroactive period for AG.

- If the individual entered the ALF or AFCH in the application month, entitlement will begin on the date the individual entered the ALF or AFCH.
- If the individual entered the ALF or AFCH prior to the month of application, entitlement will begin on the first of the month of application.
- If the individual does not meet all eligibility criteria within the month of application but meets all criteria in a subsequent month, entitlement will begin the first of the month in which all eligibility criteria are met.
- If the individual entered the ALF or AFCH in a month subsequent to the month of application, entitlement will begin on the date the individual entered the ALF or AFCH.

7.4.3.2. Entitlement Begins – Conditional Benefits

Entitlement to Conditional Benefits begins the first month after the individual receives written notification that his Agreement to Sell Property has been received and accepted.

- The date of acceptance is 5 days from the date the Conditional Benefits Notice is mailed unless the individual shows that he/she did not receive it within the 5-day period.
- If the Conditional Benefits Notice is handed to the individual, the date of acceptance is that date.

7.4.3.3. Approval Procedures

The worker must:

- Document the approval in the case record assuring that each eligibility factor is addressed.

- Assure that all supporting verifications are in the case record.
- Enter the appropriate data in the local payment system.
- Evaluate retro Medicaid eligibility based on the Medicaid Manual, Volume XIII.
- Evaluate Medicaid Eligibility. Eligibility for AG equals eligibility for ongoing Medicaid if the individual met the Declaration of Citizenship and the **Assignment of Rights requirements.**
    - **Met**
        - Enroll the individual for Medicaid in the MMIS system.
    - **Not met**
        - Document the denial and the reason for it in the case record.
- Update the MEDPEND system, using "G" as the case disposition code.
- Send the "Notice of Action" or the "Conditional Benefits Notice", as appropriate, to the individual and their representative to notify them of the AG and Medicaid decisions.
    - If Medicaid is denied, state the reason the Medicaid application was denied and cite the appropriate manual reference.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been approved.

7.5. Notices

The individual, his representative, and the ALF/AFCH provider must be notified in writing of the application decision. See Chapter B – 9.

8. Processing Renewals

Eligibility for all AG and Medicaid recipients must be renewed annually and all eligibility factors subject to change must be reverified. If a renewal is not completed, continuing eligibility cannot be determined and the case must be closed.

A renewal begins with the receipt of a written application from a non-SSI individual or the review of SVES data for an SSI recipient, continues through the verification, evaluation and documentation of each eligibility factor, and is completed at the point an eligibility decision is made, all appropriate notices are sent, and computer systems are updated.

Eligibility is established when it is redetermined that the individual meets all eligibility requirements. Ineligibility is determined at the point the individual does not meet one of the eligibility requirements. The worker must use the Evaluation of Eligibility to document the evaluation of each eligibility requirement.

8.1. Renewal Date

The initial renewal date is twelve months from the month of application. (The month of application is counted as the first month in the twelve month period.) Subsequent renewal dates will be twelve months from the last renewal month.

Example: Application was filed in March 2006. The renewal date will be February 2007. The renewal process must be completed and the MMIS system updated by the system cutoff date in February. If completed timely, the next renewal date will be February 2008.

8.2. SSI Recipients

An SSI recipient does not have to file a written application to complete his/her annual renewal. The renewal process for an SSI recipient is completed by verifying continued receipt of SSI through SVES, verifying the individual's residence in an ALF/AFCH, documenting the case record, and notifying the individual of the results of the renewal.

The renewal must be completed by the MMIS cutoff date in the renewal month.

8.3. Non-SSI Individuals

A written application is required to complete an annual renewal for a non-SSI individual. "Review Forms Parts A & B" must be mailed to the individual in sufficient time to allow for the return of the application, the provision of all required verifications, and the completion of an eligibility determination by the MMIS cutoff

date in the renewal month. The individual must be given a minimum of ten days to return the completed renewal application.

8.3.1. Renewal Application Received Late

If the renewal application is not returned timely, but is received

- Prior to the effective date of closure due to failure to complete a renewal, the application must be processed as a renewal.

  If the renewal is completed after the scheduled renewal date, the next renewal date will be twelve months from the month the renewal application was received by the agency. (The month the renewal application is received is counted as the first month in the twelve month period.)

- After the effective date of closure, a complete Application for Benefits must be submitted and the application must be processed as a reapplication. If the individual submitted Parts A & B, send the individual an Application for Benefits giving him/her 10 days to return the completed document. If the application is returned within 10 days, use the date Parts A & B were received as the individual's application date.

8.3.2. Verification Requirements

All eligibility factors subject to change must be reverified. The Manual addresses each eligibility factor and the appropriate source for the verification.

- Blindness and disability do not have to be reverified unless it is reported that the individual is no longer blind or disabled.

- The individual must be notified in writing of the items that must be verified and the date by which the verifications must be received.

- The individual must be given a minimum of ten calendar days to return the verifications. Additional time may be allowed in situations where the individual may have difficulty in obtaining the required verifications in the ten day time frame.

- If the individual asks for help in obtaining the required verifications, the eligibility worker must attempt to obtain them.

- If the required verifications are not provided and the eligibility worker is unable to obtain them, eligibility cannot be determined and the case must be closed.

8.4. Eligibility Decisions on Renewals

An AG and Medicaid eligibility decision must be made on each application for renewal and each failure to submit a renewal application. The individual and his representative must be notified in writing of that decision.

Possible decisions include:

- **Failure to comply**
  - The individual did not submit a renewal application. Case will be closed.
- **Closure**
  - The agency determines the individual is ineligible based on his failure to meet one or more of the non-financial or financial eligibility requirements. The case must be closed.
- **Suspension**

An individual's grant is suspended when

  - The individual is ineligible for one month only.
  - The worker is unable to determine the individual's continuing eligibility while awaiting an SSI eligibility decision.
- **Approval/Eligibility Continues**
  - The agency determines the individual meets all eligibility requirements and eligibility will continue.

8.4.1. Failure to Comply

If an individual does not submit a renewal application, continuing eligibility cannot be determined. The case must be closed.

8.4.1.1. Procedures

The worker must:

- Retain a copy of the cover letter that was sent to the client that stated the date by which the renewal application was to be returned.

- Document the closure and the reason for it in the case record.

- Close the case in the local payment system.

- Close the case in MMIS.

- Close the case in Med Pend.

- Send the "Advance Notice of Proposed Action" to the individual and his representative to notify them of the AG and Medicaid closures. State the reason the AG and Medicaid cases were closed and cite the appropriate AG and Medicaid manual references

- Send the "Provider/DSS Communication Form" to the ALF/AFCH to notify the provider that the AG has been closed.

8.4.2. AG Closure

When the worker determines the individual is ineligible based on his failure to meet one or more of the non-financial or financial eligibility requirements the case must be closed.

8.4.2.1. Closure Procedures

The worker must:

- Document the closure and the reason for it in the case record.

- Assure substantiation of ineligibility is included in the case record.

  Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Evaluate Medicaid eligibility based on the Medicaid Manual, Volume XIII.
    - **If eligible for Medicaid**
        - Document the approval in the case record assuring that each eligibility factor is addressed
        - Assure that all supporting verifications are in the case record.
        - Close the individual's coverage in the MMIS system as an AG individual and reopen it under the individual's new covered group.
        - Send a "Notice of Action" to the individual and his representative to notify them that Medicaid eligibility continues.
    - **If ineligible for Medicaid**
        - Document closure and reason in the case record
        - Assure substantiation of ineligibility is included in the case record.

          Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.
- Send an "Advance Notice of Proposed Action" to the individual and his representative to notify them of the AG and, if appropriate, Medicaid closures. State the reason the AG and Medicaid applications were closed and cite the appropriate AG and Medicaid manual references
- At the end of the 10 day advance notice period,
    - Close the case in the local AG payment system
    - Close the AG case in MMIS
    - Close the AG case in Med Pend

- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been closed.

8.4.3. AG Suspension

An individual's grant will be suspended when the worker determines the individual is ineligible for one month only or when the worker is unable to determine the individual's continuing eligibility while awaiting an SSI eligibility decision. A grant will be suspended for the reasons and the time periods listed below.

- The individual's receipt of a one time payment will cause ineligibility for a month.

- Inability to verify eligibility for a month.

- An individual who is required to apply for SSI has applied but SSI has not made a decision. The grant will continue to be suspended until an SSI decision is made.

Note: Suspension procedures does not apply to situations in which an individual's payment amount is reduced to zero but remains AG eligible. Zero payment might occur due to payment reconciliation, application of penalties for misuse of burial funds, etc.

8.4.3.1. Suspension Procedures - Ineligible for One Month Only

The worker must

- Document the ineligibility, the suspension, and the reason for it in the case record

- Assure substantiation of ineligibility is included in the case record

  Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Evaluate Medicaid eligibility based on the Medicaid Manual, Volume XIII.

  - **If eligible for Medicaid**

- Document the change in the case record assuring that each changed eligibility factor is addressed
- Assure that all supporting verifications are in the case record
- Close the AG Medicaid case in MMIS
- Reopen the individual in his new Medicaid covered group in MMIS
- Update the renewal date in MMIS.
- Send a "Notice of Action" to the individual and his representative to notify them that Medicaid eligibility continues.

o **If ineligible for Medicaid**

- Document the closure and the reason for it in the case record.
- Assure substantiation of ineligibility is included in the case record.
- Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.
- Send an "Advance Notice of Proposed Action" to the individual and his representative to notify them of the Medicaid closure. State the reason Medicaid was closed and cite the appropriate Medicaid manual references. This may be included on the AG Advance Notice of Proposed Action.
- At the end of the 10-day advance notice period, close the case in MMIS.

- Send an "Advance Notice of Proposed Action" to the individual and his representative to notify them of the AG suspension. State the reason for the suspension, cite the

appropriate AG manual reference, and state the date the grant will be reinstated.

- At the end of the 10-day advance notice period, suspend the case in the local AG payment system.

- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been suspended.

- Reinstate AG and Medicaid for the following month. Send a "Notice of Action" to the individual and his representative to notify them of the reinstatement.

- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been reinstated.

8.4.3.2. Suspension Procedures - Awaiting SSI Decision

The worker must

- Document the suspension and the reason for it in the case record

- Assure the case record contains substantiation of the reason for the suspension, verification that the SSI application has been filed

- Send an "Advance Notice of Proposed Action" to the individual and his representative to notify them of the AG suspension. State the reason for the suspension, and cite the appropriate AG manual reference

- At the end of the 10-day advance notice period, suspend the case in the local AG payment system

- Set a special review, in Med Pend, to check the status of the SSI decision every 30 days

- Evaluate Medicaid eligibility based on the Medicaid Manual, Volume XIII.

- **If eligible for Medicaid**
  - Document the change in the case record assuring that each changed eligibility factor is addressed
  - Assure that all supporting verifications are in the case record
  - Close the AG Medicaid case in MMIS
  - Reopen the individual in his new Medicaid covered group in MMIS
  - Update the renewal date in MMIS.
  - Send a "Notice of Action" to the individual and his representative to notify them that Medicaid eligibility continues.
- **If ineligible for Medicaid**
  - Document the closure and the reason for it in the case record.
  - Assure substantiation of ineligibility is included in the case record.
  - Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.
  - Send an "Advance Notice of Proposed Action" to the individual and his representative to notify them of the Medicaid closure. State the reason Medicaid was closed and cite the appropriate Medicaid manual references.
  - At the end of the 10-day advance notice period, close the case in MMIS.

- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been suspended.
- Upon receipt of an SSI decision, evaluate the change.

8.4.4. AG Approval/Continuing Eligibility

The agency determines the individual meets all eligibility requirements and eligibility will continue.

8.4.4.1. Grant Amount Remains Unchanged

No financial changes have occurred.

The worker must:

- Document the continuing eligibility in the case record assuring that each eligibility factor is addressed
- Assure that all supporting verifications are in the case record.
- Update the appropriate data in the local payment system
- Update the renewal date and other data in the MMIS system
- Send a "Notice of Action" to the individual and his representative to notify them of continued AG and Medicaid eligibility.

8.4.4.2. Grant Increases

There has been a decrease in the individual's income or level of need.

The worker must:

- Document the approval in the case record assuring that each eligibility factor is addressed
- Compute the new grant
- Assure that all supporting verifications are in the case record.
- Enter the appropriate data in the local payment system
- Update the renewal date in MMIS system

- Send a "Notice of Action" to the individual and his representative to notify them of continued AG and Medicaid eligibility.

8.4.4.3. Grant Decreases

The individual's income increased or there was an increase his level of need.

The worker must:

- Document the approval in the case record assuring that each eligibility factor is addressed
- Compute the new grant
- Assure that all supporting verifications are in the case record.
- Enter the appropriate data in the local payment system
- Update the renewal date in the MMIS system
- Send the "Advance Notice of Proposed Action" to the individual and his representative to notify them of continued AG and Medicaid eligibility and the decrease in the grant amount.

8.5. Notices

The individual and his representative must be notified in writing of the renewal decision. The type of action to be taken determines the specific notice to be used.

9. Processing Changes (Partial Reviews)

When a change in an eligibility factor occurs between renewals, a partial review of the individual's case is required to determine if eligibility continues and if the amount of the grant is correct.

The evaluation of a change begins with the receipt of information that a change has occurred and continues through the verification and evaluation of the change, documentation in the case record, updating of appropriate computer systems, and the mailing of a notice to the individual.

9.1. Reporting Changes

The individual must report changes in his/her situation within 10 days of the date the change occurred. The report may be verbal or in writing.

- If the individual has more than one agency worker and reports a change to any one of them, the responsibility to report has been met.

  Information that appears in the Medicaid MMIS system, in an IVES report, or that is available through the SVES inquiry system is considered to be changes that have been reported to the agency and the individual's requirement to report has been met.

  The eligibility worker is responsible for identifying these changes and must take action on them within the time frames noted in Chapter B - 9.2.

9.1.1. Failure To Report Timely

If the individual fails to report a change timely, a change that was not otherwise known to the agency, determine if the change resulted in an increase or decrease in the individual's grant.

9.1.1.1. Grant Increase

Implement the change as instructed in Chapter B - 8.4.4.2.

- The individual is entitled to supplements from the month of change forward. The supplements will be addressed at the point the impacted months are reconciled. See Reconciling Payments Chapter J – 7.

9.1.1.2. Grant Decrease

Determine if an overpayment has occurred. Implement the change as instructed in Chapter B - 8.4.4.3.

- Determine the month in which the change occurred and should have been reported.

- Use the Change Time Standards in Chapter B - 9.2 below to determine the month the change should have been implemented had it been reported timely.

  - Overpayments occurred in the month the change should have been implemented and each subsequent

month that occurred prior to the actual implementation of the change.

Example: Individual's support income increased on January 1st. He reported the change in April. An Advance Notice of Proposed Action was mailed notifying him that his grant would be decreased effective June.

The individual should have reported the change by January 11th. The change would have been implemented for March, the second month following the month in which the change was to be reported. Overpayments occurred in March, April, and May.

- Determine the total amount of the overpayment.
- Take action to recover the total overpayment as directed in Chapter L.

9.2. Change Time Standards

Action must be taken on reported changes within a timeframe that permits the worker to meet the effective date guidelines given below.

9.2.1. Increase In Grant Amount

9.2.1.1. Increase in Grant Amount Due to Income Change

Action must be taken within 30 days of the date the change was reported. The individual will be due supplements for each month impacted by the change. The supplements will be issued at the point the impacted period is reconciled. See Reconciling Payments Chapter J – 7.

9.2.1.2. Increase In Grant Amount Due To An Increase In ALF & AFCH Rates

Increases made necessary by an increase in the monthly rate permitted to be charged by an ALF/AFCH, must be made retroactive to the effective date of the rate increase. The supplements must be issued at the point the determination is made. Do not wait until the impacted months are reconciled.

Example: The AG rate increases effective January 1. Case action is taken on February 5. The increase must be effective January 1. A supplement is required for January and February and is initiated on February 5.

9.2.2. Termination/Decrease In The Grant

If a decrease in the amount of the grant or termination of assistance is required, the reduced payment or nonpayment of assistance must be effective as soon as administratively possible, the first of the month following the end of the 10-day advance notice period, but no later than the second month following the month in which the change is reported.

Example: A change is reported on July 26. Action must be taken by the August Med Pend cutoff date (approximately August 16) to make the decrease effective September 1.

9.2.2.1. Advance Notice

The individual must be given 10 days advance notice of a proposed decrease or termination of his grant. Unreduced payments issued during the advance notice period are not over payments.

Example: On July 10th the individual reported that his income increased effective July 1st. On July 23rd the EW computes the new grant amount and prepares an "Advance Notice of Proposed Action". The advance notice period is 10 days, July 24th through August 2nd. The notice will state the reduced grant will be effective September 1st. The EW can take action to reduce September's grant on August 3rd. The August grant is not an overpayment.

Exception to the 10-day advance notice requirement

- The individual requests the case be closed.
- The individual's death has been verified.
- The individual was discharged from the facility.

9.3. Verification Requirements

All changes in eligibility requirements must be verified.

- A request for a case to be closed must be made in writing and be signed and dated by the individual or his representative.

- The individual must be notified in writing of the items that must be verified and the date by which the verifications must be received.

- The individual must be given a minimum of 10 days to return the verifications. Additional time may be allowed in situations where the individual may have difficulty in obtaining the required verifications in the ten day time frame.

- If the individual asks for help in obtaining the required verifications, the eligibility worker must attempt to obtain them.

9.3.1. Verification Not Provided

If the required verifications are not provided and the eligibility worker is unable to obtain them, continued eligibility cannot be determined and the case must be closed.

9.4. Eligibility Decisions on Changes

An eligibility decision must be made on each reported change. The individual and his representative must be notified in writing of that decision.

Possible decisions include:

- **Ineligibility/Closure**

  - The agency determines the individual is ineligible based on his failure to meet one or more of the non-financial or financial eligibility requirements and the case must be closed.

  - The agency receives information verifying the death of the individual.

  - The individual requests his case be closed.

- **Suspension**

  An individual's grant is suspended when

  - The individual is ineligible for one month only.

  - The worker is unable to determine the individual's continuing eligibility while awaiting an SSI eligibility decision.

- **Eligibility Continues**

The agency determines the individual meets all eligibility requirements and eligibility will continue.

9.5. Ineligibility/Closure

When the agency determines the individual is ineligible based on his failure to meet one or more of the non-financial or financial eligibility requirements, the individual requested the case closed, or the individual died, the case must be closed.

The worker must

- Assure substantiation of ineligibility is included in the case record.

  Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Evaluate Medicaid eligibility based on Medicaid Manual, Volume XIII.

  - **If Medicaid eligible**

    - Document the change in the case record assuring that each changed eligibility factor is addressed.

    - Assure that all supporting verifications are in the case record.

    - Close the AG Medicaid case in MMIS.

    - Reopen the individual in his new Medicaid covered group in MMIS

    - Send a "Notice of Action" to the individual and his representative to notify them that Medicaid eligibility continues.

  - **If Medicaid ineligible**

    - Document the closure and the reason for it in the case record

    - Assure substantiation of ineligibility is included in the case record.

      - Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Send an "Advance Notice of Proposed Action" to the individual and his representative to notify them of the AG and, if appropriate, Medicaid closures. State the reason AG and Medicaid were closed and cite the appropriate AG and Medicaid manual references.

- At the end of the 10-day advance notice period close the case in the local AG payment system, the MED Pend system, and, if appropriate, MMIS.

    - **Exception: A 10-day advance notice period is not required when an individual requests his case closed.**

- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been closed.

9.6. Suspension

An individual's grant will be suspended when the worker determines the individual is ineligible for one month only or when the worker is unable to determine the individual's continuing eligibility while awaiting an SSI eligibility decision. A grant will be suspended for the reasons and the time periods listed below. Medicaid eligibility based on AG eligibility ends at the point the AG payment is suspended. Medicaid eligibility for the suspension period will have to be evaluated based the Medicaid Manual, Volume XIII.

Reasons for suspension:

- The individual's receipt of a one-time payment will cause ineligibility for a month.

- Inability to verify eligibility for a month.

- An individual who is required to apply for SSI has applied but SSI has not made a decision. The grant will continue to be suspended until an SSI decision is made.

9.6.1. Suspension Procedures - Ineligible for One Month Only

The worker must

- Document the ineligibility, the suspension, and the reason for it in the case record.

- Assure substantiation of ineligibility is included in the case record.

Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Evaluate Medicaid eligibility based on the Medicaid Manual, Volume XIII.

  - **If Medicaid eligible**

    - Document the change in the case record assuring that each changed eligibility factor is addressed.

    - Assure that all supporting verifications are in the case record.

    - Close the AG Medicaid case in MMIS

    - Reopen the individual in his new Medicaid covered group in MMIS.

    - Send a "Notice of Action" to the individual and his representative to notify them that Medicaid eligibility continues.

  - **If Medicaid ineligible**

    - Document the closure and the reason for it in the case record.

    - Assure substantiation of ineligibility is included in the case record.

      Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

    - Send an "Advance Notice of Proposed Action" to the individual and his representative to notify them of the Medicaid closure. State the reason Medicaid was closed and cite the appropriate Medicaid manual references. This information can be included on the AG Advance Notice of Proposed Action.

    - At the end of the 10-day advance notice period close the case in MMIS.

- Send an "Advance Notice of Proposed Action" to the individual and his representative to notify them of the AG suspension. State the

reason for the suspension, and cite the appropriate AG manual reference.

- At the end of the 10-day advance notice period, suspend the case in the local AG payment system.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been suspended.
- Reinstate AG and Medicaid for the following month. Send a "Notice of Action" to the individual and his representative to notify them of the reinstatement.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been reinstated.

9.6.2. Suspension Procedures - Awaiting SSI Decision

The worker must

- Document the suspension and the reason for it in the case record.
- Assure the case record contains substantiation of the reason for the suspension, verification that the SSI application has been filed.
- Evaluate Medicaid eligibility based on the Medicaid Manual, Volume XIII.
    - **If Medicaid eligible**
        - Document the change in the case record assuring that each changed eligibility factor is addressed.
        - Assure that all supporting verifications are in the case record.
        - Close the AG Medicaid case in MMIS.
        - Reopen the individual in his new Medicaid covered group in MMIS.
        - Send a "Notice of Action" to the individual and his representative to notify them that Medicaid eligibility continues.
    - **If Medicaid ineligible**

- Document the closure and the reason for it in the case record.
- Assure substantiation of ineligibility is included in the case record.
- Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.
- Send an "Advance Notice of Proposed Action" to the individual and his representative to notify them of the Medicaid closure. State the reason Medicaid was closed and cite the appropriate Medicaid manual references.
- At the end of the 10-day advance notice period close the case in MMIS.

- Send an "Advance Notice of Proposed Action" to the individual and his representative to notify them of the AG suspension. State the reason for the suspension, and cite the appropriate AG manual reference.
- At the end of the 10-day advance notice period, suspend the case in the local AG payment system.
- Set a special review to check the status of the SSI decision every 30 days.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been suspended.
- Upon receipt of an SSI decision, evaluate the change.
  - See Chapter B.8 for renewal procedures and Chapter B.9 for change procedures.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been reinstated.

9.7. Continuing Eligibility

The agency determines the individual meets all eligibility requirements and eligibility will continue.

9.7.1. Grant Amount Remains Unchanged

No financial changes have occurred.

The worker must:

- Document the change in the case record assuring that each changed eligibility factor is addressed.
- Assure that all supporting verifications are in the case record.
- Send a "Notice of Action" to the individual and his representative to notify them of continued AG and Medicaid eligibility.

9.7.2. Grant Increases

There has been a decrease in the individual's income or level of need.

The worker must:

- Document the change in the case record assuring that each changed eligibility factor is addressed.
- Compute the new grant.
- Assure that all supporting verifications are in the case record.
- Enter the appropriate data in the local payment system.
- Send a "Notice of Action" to the individual and his representative to notify them of the increased grant amount.

9.7.3. Grant Decreases

The individual's income increased or there was a decrease his level of need.

The worker must:

- Document the change in the case record assuring that each eligibility factor is addressed.
- Compute the new grant.
- Assure that all supporting verifications are in the case record.

- Send the "Advance Notice of Action" to the individual and his representative to notify them of the decrease in the grant amount.

- At the end of the 10 day advance notice period, enter the appropriate data in the local payment system. The effective date of a decrease will be the first of the month following the expiration of the advance notice period.

9.8. Notices to Individual and Provider

The individual and his representative must be notified in writing of the results of the change evaluation. The type of action to be taken determines the specific notice to be used. The provider must be notified if the change results in the individual's ineligibility. See Chapter B – 9.5.

10. Notices

The individual and his representative must be notified in writing of decisions on applications, renewals, and the results of change evaluations. The type of action to be taken determines the specific notice to be used.

The provider must be notified of initial eligibility decisions and any changes that result in the individual's ineligibility. The Provider/DSS Communication Form is used to notify the providers. This form is located on SPARK at http://spark.dss.virginia.gov/divisions/dgs/warehouse.cgi.

10.1. AG Notice of Action

The "AG Notice of Action" is used to notify an individual of the approval or denial of his/her initial application or reapplication for regular AG and when his/her annual renewal or change evaluation results in continued eligibility at the same or higher payment level.

10.1.1. Initial Application/Reapplication

The notice must be mailed at the time a decision is made on the application and within the 45-day processing period.

- If a decision has not been made by the 45th day, a "Notice of Action" must be mailed to the individual on the 45th day. The notice must

state that the application is still pending and the reason action was not taken within the 45 day processing period.

10.1.2. Renewal or Change

The notice must be mailed at the time a decision is made.

10.2. Conditional Benefits Notice

The "Conditional Benefits Notice" is a multipurpose form. It is used to notify an individual of his/her potential eligibility for Conditional Benefits, approval of Conditional Benefits, and the termination of Conditional Benefits. See Chapter F.

10.2.1. Initial Application/Reapplication

The "Conditional Benefits Notice" is used at two points in the application eligibility determination process.

10.2.1.1. Potential Eligibility

The "Conditional Benefits Notice" must be mailed within the 45-day processing period to inform the individual of his ineligibility for regular AG due to excess non-liquid resources and his potential eligibility for Conditional Benefits. An "Agreement to Sell Non-Liquid Resources" must be sent with the notice.

10.2.1.2. Eligibility Approved

The "Conditional Benefits Notice" must be mailed at the point it is determined the individual is eligible for Conditional Benefits. It must be mailed within 60 days from the date of application.

10.2.2. Renewal or Change

The "Conditional Benefits Notice" is used as an advance notice of proposed action to notify an individual that he/she is no longer eligible for Conditional Benefits.

10.2.2.1. Time Frames

The individual must be given a minimum of 10 days advance notice before his/her case can be closed.

- The "Conditional Benefits Notice" must be completed

and mailed at least 11 days prior to the effective date of the proposed case closure. The notice must state the effective date, the reason for the action, and cite the supporting manual reference.

- The effective date of the closure will be the first of the month following the expiration of the advance notice period.

10.3. Advance Notice of Proposed Action

The "Advance Notice of Proposed Action" is the form used to notify an individual that his/her renewal or change has been evaluated and that

- Eligibility continues but the grant amount will be reduced,
- The grant is being suspended, or
- Eligibility no longer exists.

10.3.1. Time Frames

The individual must be given a minimum of 10 days advance notice before an adverse action can be taken on the case.

Exception: A 10-day advance notice period is not required when an individual requests case closure.

- The "Advance Notice of Proposed Action" must be completed and mailed at least 11 days prior to the effective date of the proposed decrease or case closure. The notice must state the effective date, the reason for the action, and cite the supporting manual reference.
- The effective date of an adverse action will be the first of the month following the expiration of the advance notice period.

10.4. Transfer of Resources Notice

The Transfer of Resources Notice is used to notify an individual that they are ineligible for a period of time due to the uncompensated transfer of resources, to inform them of their right to claim undue hardship and to notify them of any

adjustments made to the period of ineligibility. See Chapter G.

10.4.1. Initial Application/Reapplication

The "Transfer of Resources Notice" is to be sent with the Notice of Action.

10.4.2. Renewal or Change

The "Transfer of Resources Notice" is to be sent with the "Advance Notice of Proposed Action."

10.5. Provider/DSS Communication Form

The Provider/DSS Communication Form is used to notify the provider of the eligibility decision. The form is also used as means of communication between the local DSS and the assisted living facility or adult foster care home provider. They can exchange information regarding:

- The AG and Medicaid eligibility status of a patient;
- Admission or discharge of a patient to home, hospital, another ALF/AFCH, or an institution, or to report the death of a patient;
- Other information known to the provider that might cause a change in the eligibility status.

10.5.1. Use of the Form

The form may be initiated by either the local DSS or the provider of care. The local DSS must complete the form for each applicant at the time initial eligibility is determined. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in the individual's ineligibility.

The provider must use the form to show admission date, to request information on AG or Medicaid eligibility status, to request a Medicaid recipient I.D., or to notify the local DSS of changes in the patient's circumstances, discharge or death.